

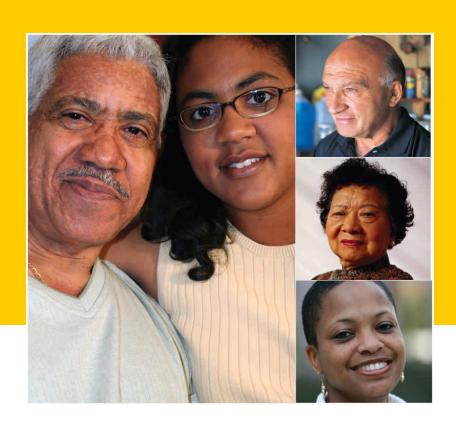
HOW CAN WE HELP YOU TO HELP YOUR PATIENTS?

DECEMBER 8, 2011

TAMI KELDER, ASSOCIATE HI DIRECTOR, KY



Cancer Resource Network







1.800.227.2345 www.cancer.org

Cancer Resource Network



Umbrella name for the Society's programs and services available to assist persons affected by cancer

<u>Goals</u>

- Deliver timely information and support programs
- Promote informed decision making
- Enhance quality of life for survivors and caregivers



Benefits to referring patients to the American Cancer Society



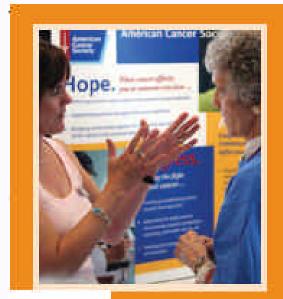
Having cancer is hard. Finding help shouldn't be.
The American Cancer Society can help.

- Easy to understand information to help you make decisions about your care.
- Referral for day-to-day questions such as financial, insurance, transportation, and lodging.
- Connection to others who have been there for emotional support.



Information









- Free detailed information packets available for all types of cancer.
- Phone help: 1-800-227-2345
- On the internet: www.cancer.org
- Tools to help with treatment













- Look Good Feel Better
- Wigs & Prosthesis
- Lodging and transportation assistance
- Help with financial and insurance questions
- Prescription drug assistance









- Reach to Recovery
- Finding local support groups
- Online community for cancer patients and their families
- Cancer education classes





Direct Fax Referral Program: What Is It?

A simple new method for referring patients to the American Cancer Society for information, day-to-day help or emotional support.



Direct Fax Referral Program: What Do Patients Receive?



- Information from the American Cancer Society about their cancer diagnosis.
- A direct link to the American Cancer Society's services and resources.
- The empowering force of reliable information.





Direct Fax Referral Program: What Do Clinicians Receive?

- Peace of mind that patients receive trustworthy cancer information from the American Cancer Society.
- The satisfaction that well-informed patients understand their cancer better and are better equipped to make decisions.



How do we refer patients to these programs?



Patient's Name	Email
Home Address	
City/State/Zip	
Primary Ph # ()	
Best time to call DAM D	PM OK to leave message identifying ourselves as ACS? ☐Yes ☐No
00B (M/D/Y) / / /	Gender M F Primary Language English Spanish
Race □ African American/Black □ Hispanic/Latino	American Indian/Alaska Native Asian Caucasian/White Dacific Islander
Date of Cancer Diagnosis (Month/	Wear) I Type of Cancer (primary ste)
nsurance (check all that apply)	Private Medicare Medicaid/TennCare Military Program Uninsured Dec
SELECT ONE	
☐ INFORMATION PACKET O	ONLY: Free information is sent within 1-2 business days of ACS receiving this form.
OR	
Look Good Feel Bet Reach to Recovery (bre Other resources	d for the patient/caregiver: etter (female cancer patients only) assic cancer patients only)
☐ Transportation	
☐ Transportation COMMENTS	
COMMENTS	tall OR ☐ Email (reconfirm)
COMMENTS Send information packet by Ma	iail OR Email (reconfirm)
COMMENTS Send information packet by Me Instead of patient, contact the foll	An An An
COMMENTS Send information packet by Ma Instead of patient, contact the foll Name	ollowing if resources are requested: Family Member Caregiver Health Profess
COMMENTS Send information packet by Ma Instead of patient, contact the foll Name Primary Phone ()	Nowing if resources are requested: Family Member Caregiver Health Profess
Send information packet byMa Instead of patient, contact the foll Name Primary Phone () Kentucky Women's Cancer	slowing if resources are requested: Family Member Caregiver health Profess Email CK to leave message? Yes No
Send information packet by Ma Instead of patient, contact the foll Name Primary Phone () _ Kentucky Women's Cancer Referring Clinician's Name (print	stowing if resources are requested: Family Member Caregiver health Profess Email OK to leave message? Yes No Screening Program 1-2GDGJKC
COMMENTS Send information packet by Market instead of patient, contact the following Primary Phone () Kentucky Women's Cancer Referring Clinician's Name (print Department	Screening Program 1-2GDGJKC Primary Ph # (
COMMENTS Send information packet by Management Send information packet by Management Send of patient, contact the following Send of S	Screening Program 1-2GDGJKC Primary Ph # (



Section 1 of Referral form—Basic Information



Patient Referral Form

Please print clearly for prompt service.

For immediate assistance call us anytime at 1-800-ACS-2345.



Patient's Name	Email
Address/City/State/Zip	
Primary Ph # ()	Vk Cell Alternate Ph # () Hm Wk Cell
Best time to call □AM □PM	OK to leave message identifying ourselves as ACS? ☐Yes ☐No
DOB (M/D/Y)//	Gender M F
African American/Black American Hispanic/Latino Pacific Isl	Indian/Alaska Native Asian Caucasian/White ander Other
Primary Language English Spanish	
Date of Diagnosis (Month/Year)/_	Type of Cancer (site)
Insurance (check all that apply) Private Medica	are Medicaid Military Program Uninsured Declined



Referral form section 2– Level of follow-up



SELECT ONE LEVEL OF FOLLOW UP

INFORMATION ONLY: Patient receive information packet
SERVICES NEEDED: Patient wants free information but ALSO should receive follow up call within 2 business days for assessment of resources and programs as indicated. Provide any needed details in the COMMENTS box.
Lodging
Look Good Feel Better
Reach to Recovery
Other resources
Transportation



Referral section 3— Patient consent



PATIENT'S CONSENT (HIPAA): Patient understands the HIPAA policy and agrees with the disclosure of this information to the American Cancer Society for the purposes of applicable follow up. The American Cancer Society is a private organization and does not share personal health information.

PATIENT'S SIGNATURE (if applicable)



Referral form section 4— Facility Contact Information



Kentucky Women's Cancer Screening Program	n 1-2GDGJKC			
Referring Clinician's Name (print)		Primary Ph # ()		
Department Clinician's Email				
PATIENT'S CONSENT (HIPAA): Patient understands information to the American Cancer Society for the purpos organization and does not share personal health information	ses of applicable follo			
PATIENT'S SIGNATURE				
Email to: midsouth.cancerinfo@cancer.org		FAX form to: 1-866-265-0564		





THANK YOU FOR TEAMING UP WITH US TO HELP YOUR PATIENTS QUALITY OF LIFE.

